

New Hampshire Medicaid Expansion Waiver

Overview

New Hampshire expanded Medicaid to adults with income below 138 percent of the federal poverty level (FPL) in 2015 under the Patient Protection and Affordable Care Act (ACA, P.L. 111-148, as amended) using a Section 1115 waiver effective January 1, 2016. This waiver established the New Hampshire Health Protection Program (NHHPP), a mandatory premium assistance program for individuals in the new adult group using exchange plans, approved through December 31, 2018. In May 2018, the Centers for Medicare & Medicaid Services (CMS) approved New Hampshire's amendment request to add a work and community engagement requirement as a condition of eligibility beginning in 2019.^{1,2}

Demonstration Goals

Under the most recently approved waiver, the state is seeking to accomplish several goals. The demonstration goals will inform the hypotheses in the state's evaluation design plan and include—but are not limited to—determining whether the demonstration aided in:

- providing continuity of coverage,
- improving plan variety for both Medicaid-funded premium assistance enrollees and exchange enrollees,
- reducing the cost of coverage relative to direct Medicaid coverage,
- promoting access to primary, specialty, and behavioral health services, and
- improving health outcomes and promoting independence through employment and community engagement.³

Populations Covered

The demonstration covers adults age 19 to 64 with incomes at or below 138 percent of the federal poverty level (FPL). Individuals who are medically frail, eligible for Medicare, or eligible for the state Health Insurance Premium Payment (HIPP) program because they have access to cost-effective employer sponsored insurance are exempted from mandatory exchange plan premium assistance and from the work and community engagement requirements.



Eligibility and Enrollment

New Hampshire's waiver program includes changes to traditional Medicaid eligibility and enrollment requirements including a conditional waiver of the Medicaid requirement to provide enrollees with three months of retroactive eligibility and a work and community engagement requirement.

Effective date of coverage

The demonstration includes a provisional waiver of retroactive coverage, conditioned upon the state providing data to CMS demonstrating that retroactive coverage prior to the date of application is not necessary to fill gaps in coverage. Following a decision by CMS that the state has met the requirement to provide sufficient data establishing seamless coverage, the state will not be required to provide retroactive coverage and coverage will begin at the date of application.

Work and community engagement requirement

Beginning no sooner than January 1, 2019, New Hampshire will require members of the new adult group to fulfil work and community engagement requirements after a 75-day grace period.⁴ Under the new requirements beneficiaries must either meet an exemption or complete at least 100 hours of qualifying activities during any given month. Beneficiaries without an exemption must report their participation in qualifying activities, and be able to provide supporting documentation when requested.⁵

TABLE 1. Work and Community Engagement Requirement Exemptions and Qualifying Activities

Exempt populations	Non-exempt populations
<p>Beneficiaries who are:</p> <ul style="list-style-type: none"> temporarily unable to participate due to illness or incapacity as documented by a licensed provider or identified as medically frail; participating in a state-certified drug court program; parents or caretakers of a dependent child under age six, child of any age with a disability, or a dependent individual whose care is considered necessary by a licensed provider; pregnant or 60 days or fewer post-partum; disabled or residing with an immediate family member with a disability as defined by ADA Section 504 or ACA Section 1557 who are unable to comply with the requirement due to reasons related to that disability; experiencing (or recently experienced) a hospitalization or serious illness, or are residing with a family member who experiences a hospitalization or serious illness; exempt from SNAP or TANF work requirements; enrolled in New Hampshire's voluntary Health Insurance Premium Program. 	<p>Required participation in 100 hours per month of some combination of the following:</p> <ul style="list-style-type: none"> unsubsidized or subsidized employment; on-the-job or skills training related to employment; enrollment at an accredited community college, college, or university that is counted on a credit hour basis job search and readiness assistance (e.g., activities required to receive unemployment benefits, services offered by the Department of Employment Security); vocational educational training (up to 12 months); education directly related to employment (for individuals who have not graduated high school) attendance in secondary school or in a course of study leading to certificate of high school equivalency; participation in SUD treatment; community and public service; caregiving services for a non-dependent relative or other person with a disabling health, mental health, or developmental condition; and compliance with SNAP or TANF work requirements.



TABLE 1. (continued)

Notes. ACA is Patient Protection and Affordable Care Act (P.L. 111-148, as amended). ADA is the Americans with Disabilities Act (P.L. 101-336). SNAP is Supplemental Nutrition Assistance Program. TANF is Temporary Assistance for Needy Families. SUD is substance use disorder. In two-parent families, only one parent may qualify for the exemption for parents and caretakers of dependent children under age six.

Source. CMS 2018.

Penalties for non-compliance. For beneficiaries who fail to meet the work and community engagement requirement for one month, Medicaid eligibility will be suspended at the end of the following month (i.e., two months after the initial failure to meet requirements). Beneficiaries will be able to avoid suspension if they apply for and receive a good-cause exemption, meet the qualifications for exemption, make up deficient participation hours, or become eligible for Medicaid under an eligibility category not subject to the requirements.⁶ Beneficiaries whose eligibility is suspended can reactivate it at any time without reapplying for Medicaid by satisfying one of the same criteria used to avoid suspension, however, if a beneficiary's eligibility is suspended on the date of his or her annual redetermination, eligibility will be terminated. Individuals whose coverage is terminated for non-compliance can reapply for coverage at any time.⁷

State assurances. Prior to implementing these requirements, New Hampshire is required to make a number of assurances. These include:

- setting up and maintaining system capability to implement and conduct key administrative functions, such as suspending eligibility and lifting those suspensions and suspending and reactivating capitation payments to exchange plans;
- allowing beneficiaries to report work or community engagement hours, and
- seeking data from other sources such as the Supplemental Nutrition Assistance Program and Temporary Assistance for Needy Families.

New Hampshire is also required to make assurances aimed at beneficiary protection, including that it will:

- ensure timely and adequate beneficiary notices and outreach;
- provide appeal and due process mechanisms, make good faith efforts to connect beneficiaries to existing community supports (e.g., non-Medicaid transportation assistance, child care, or language services);
- assess areas within the state that have limited employment or educational opportunities to determine whether further exemptions are necessary; and
- provide reasonable modifications for individuals with disabilities.

Additionally, New Hampshire must submit an eligibility and enrollment monitoring plan to CMS within 90 calendar days of the waiver amendment approval. The plan must include a detailed project implementation plan including metrics, timelines, and programmatic content. For example, the state must ensure that it is capable of collecting metrics such as the number and percentages of individuals who are exempt, are required to report participation hours, requested good cause exemptions, were disenrolled for non-



compliance, and more. New Hampshire is not permitted to take adverse action on a beneficiary for non-compliance with work and community engagement requirements prior to CMS approval of the plan.

Benefits

Beneficiaries will receive the alternative benefit plan (ABP) through an exchange plan they select. Benefits provided through the ABP will not differ from those provided under the Medicaid state plan. Medicaid benefits that are not offered through the exchange plan will be provided by the state Medicaid program. Specifically, the state will provide a wrap-around benefit for non-emergency medical transportation (NEMT), Early Periodic Screening, Diagnosis, and Treatment (EPSDT) for 19- and 20-year-olds, and adult vision and limited adult dental services. The state will also cover out-of-network family planning services and supplies and certain limited dental and adult vision services. Requests for prior authorization for prescription drugs must be addressed within 72 hours instead of 24 hours as was previously required under New Hampshire policy.

Premiums and Cost Sharing

Enrollees with incomes between 100 percent and 138 percent FPL will be responsible for cost-sharing in amounts ranging from \$3 to \$8 for primary and specialty care visits, and up to \$125 for inpatient hospital, mental health, or substance use disorder services as described in the state plan. Consistent with Medicaid cost-sharing rules, aggregate cost sharing is capped at 5 percent of household income. Individuals with incomes below 100 percent FPL will not have cost-sharing obligations.

Premium Assistance

Enrollees have the option of choosing from at least two exchange plans among all silver plans offered in their geographic area, and can select their plan through an online portal, by phone, or in person. Those who do not select a plan are auto-assigned to one. Enrollees receive coverage through the state's fee-for-service Medicaid until enrollment in the exchange plan is finalized. Individuals determined to be medically frail receive direct Medicaid coverage and are not permitted to enroll in exchange plan premium assistance.

Delivery System

Enrollees will have access to the same networks as other exchange plan enrollees. Services described above that are not provided through the exchange plan will be provided through the Medicaid fee-for-service delivery system. Premium assistance enrollees also must have access to at least one exchange plan that contracts with at least one federally qualified health center or rural health center.

For a summary of the Section 1115 waivers used to expand Medicaid to the new adult group please see [Expanding Medicaid to the New Adult Group through Section 1115 Waivers](#).



Endnotes

¹ Because the waiver is authorized only through the end of 2018 and work and community engagement requirements will not take effect until 2019, New Hampshire will need to request a renewal of the waiver in order to go forward with these requirements.

² For information on other states with approved or pending requests to implement work requirements, see [Medicaid Work and Community Engagement Requirements](#).

³ Because New Hampshire's waiver program is a demonstration, it requires evaluation by an independent entity. New Hampshire is required to develop an evaluation designed to assess whether the demonstration is meeting its stated goals. An evaluation design plan is due to CMS within 90 days of demonstration or amendment approval, an interim evaluation report is due within 90 days following completion of demonstration year 2 (CY 2017), a summative evaluation report is due within 180 days of the expiration of the demonstration, and a final summative report is due within 360 days of the expiration of the demonstration.

⁴ Though CMS specified that the effective date of these requirements may be no sooner than January 1, 2019, New Hampshire has not determined an exact effective date. The state must notify CMS of its intent to implement these requirements 30 days in advance.

⁵ New Hampshire must allow beneficiaries to submit documentation in accordance with process requirements for verifying eligibility criteria at 42 CFR 435.916(c) requiring states to provide multiple means of submission (e.g., online, via mail, other electronic means).

⁶ Good cause exemptions must include, at minimum, circumstances that occur in the month in which the beneficiary failed to meet the requirements, such as, the beneficiary or an immediate family member has a disability or is hospitalized for a serious illness, the birth or death of a family member, severe inclement weather or a natural disaster, or a family emergency or life changing event (e.g., divorce or domestic violence).

⁷ Beneficiaries whose eligibility is terminated at renewal for this reason will have to submit a new Medicaid application, but their previous non-compliance will not be factored into the new eligibility determination.

Reference

Centers for Medicare & Medicaid Services (CMS), U.S. Department of Health and Human Services. 2018. Section 1115 of the Social Security Act Medicaid demonstration amendment: New Hampshire Health Protection Program Premium Assistance. May 7, 2018. <https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/nh/nh-health-protection-program-premium-assistance-ca.pdf>

